

Case Number:	CM15-0141767		
Date Assigned:	08/06/2015	Date of Injury:	11/04/2006
Decision Date:	10/06/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/21/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 65-year-old male, who sustained an industrial injury on 11-04-2006. He has reported injury to the left shoulder. The diagnoses have included left shoulder impingement and rotator cuff tear; acromioclavicular joint osteoarthritis; and left shoulder full-thickness supraspinatus tendon tear with retraction. Treatment to date has included medications, diagnostics, injection, and physical therapy. Medications have included Norco. A progress note from the treating physician, dated 05-26-2015, documented a follow-up visit with the injured worker. The injured worker reported left shoulder pain since his injury; he was advised that surgery was indicated; and he is being seen for a second opinion. Objective findings included decreased ranges of motion of the left shoulder; supraspinatus, greater tuberosity, and acromioclavicular joint tenderness to palpation; atrophy noted at left shoulder; muscle strength and tone is rated 4 out of 5 with forward elevation, abduction, and external rotation; the shoulder movement is painful; distal sensation is normal to light touch; impingement tests and acromioclavicular joint compression test are positive on the left; and MRI of the left shoulder, dated 06-07-2013 revealed a full-thickness rotator cuff supraspinatus-infraspinatus tendon tear with 1 cm of retraction. The treatment plan has included the request for left shoulder arthroscopy, possible arthroscopic vs open rotator cuff debridement vs repair, decompression with acromioplasty, resection of coracoacromial ligament and-or bursa as indicated Mumford procedure; associated service: assistant surgeon; pre-op medical clearance; pre-op toxicology urine testing; associated service: cold therapy unit (duration and frequency unknown); associated service: E-stim (duration and frequency unspecified); associated service: sling with large

abduction pillow; associated service: CPM (continuous passive motion) unit (duration and frequency unspecified); post-op DVT (deep vein thrombosis) compression home unit with bilateral calf; post-op physical therapy 3 x 6; associated service: home shoulder physical therapy exercise kit (purchase).

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Left Shoulder Arthroscopy, possible arthroscopic vs open rotator cuff debridement vs repair, decompression with acromioplasty, resection of coracoacromial ligament and/or bursa as indicated Mumford procedure: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation, 18th Edition, 2013 updates, Surgery for impingement syndrome; Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition, the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally, there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case, the objective findings are sufficient to demonstrate rotator cuff tear. There is however, no record submitted demonstrating the e failure of physical therapy or injection management. Without clear failure of non-surgical treatment, the request is not medically necessary.

Associated service: Assistant Surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-op Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-op Toxicology Urine Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated service: Cold Therapy Unit (duration & frequency unknown): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated service: E-stim (duration & frequency unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated service: Sling with large abduction pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated service: CPM Unit (duration & frequency unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op DVT compression home unit with bilateral calf: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-op Physical Therapy 3 x 6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated service: Home Shoulder Physical Therapy Exercise Kit (purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.